Denali Commission
Rural Primary Care Facility Project

Business Plan

Applicant Name

The purpose of this Business Plan is to demonstrate:

1) **That the Applicant has the financial and managerial ability to provide health care services and to maintain the facility.**

2) **That the Applicant has identified the services that will be provided in the new facility.**

Successful completion of this step and the rest of the Conceptual Planning products will lead the Applicant into the Facility Design and Construction process for a new or renovated healthcare facility.

Note – If the construction project is not started within 24 months after the Business Plan is approved, the Plan must be updated before Construction Funds can be awarded.

Send one copy of your Business Plan to:
Denali Commission
Attn: Rural Primary Care Facilities Business Plan
510 "L" Street
Suite 410 (Peterson Tower)
Anchorage, Alaska 99501

Contact your Technical Assistance Subcommittee advisor if you have questions

Denali Commission

Alaska Primary Care Association

State of Alaska
Dept of Public Health
Community Health/EMS

Alaska Center for Rural Health

Denali Commission Business Plan - Table of Contents

1. INTRODUCTION

This document has been prepared as a Microsoft Word document. The text boxes after each question will expand as you type in your answers.

Note that Forms B – G are also available in Excel format.

Some sections require attachments. They are numbered based upon the section number and the order. For example, Section 3 first attachment will be 3.1, second attachment will be 3.2. Not all sections require attachments. A list of attachments is provided in section 10.

There are a variety of forms used to complete the financial information in section 13.

When you have completed the Business Plan, submit it to the Denali Commission Technical Assistance Subcommittee (TASC) for review.

Once approved, you should be ready to move into the formal Facility Design stage. This stage will finalize site control issues, resolve any design issues, determine project costs and produce architectural documents. Construction is the final stage of this process.

2. BUSINESS PLAN SUMMARY

A. Summary Form

Applicant Information		
Name of Applicant		
Community(ies) to be served:		
Descriptive Title of Proposal:		
Construction Project / Cost Summary		
	Existing Clinic	**Total New/Expanded Clinic**
Clinic Square Footage		
Non-Clinic Square Footage (include description of multi-use space)		
Total Bldg Square Footage		
Estimated Cost of Project:	$	
Applicant Cost Share:	$	
Amount Requested from Denali Commission:	$	

Budget Summary Recap			
Form B–Budget Summary	**Existing Clinic**	**Projected Budget – New/Expanded Clinic**	
		Year 1	**Year 2**
TOTAL REVENUE (Line 6)			
TOTAL EXPENSES (Line 15)			
REVENUE OVER/(UNDER) EXPENSES (Line 6 minus 15)			

Applicant Contacts	
Contact Person: Name: Phone # and Fax #: E-mail address:	(A person who filled out the Business Plan and can answer questions about it)
Representative Name: Phone # and Fax #: E-mail address:	(A person who can conduct business on behalf of the Applicant)
Representative Signature:	
Date Signed:	

B. Executive Summary

You must include a 1-2 page Executive Summary. This should be prepared AFTER all of the individual components have been completed.

Summarize the important factors that went into your decision to apply for Denali Commission funds. Explain who you are, why you need a new clinic, how your proposal will meet the specific needs of your community, and how you will be able to maintain and support health care services and the clinic building (financially and otherwise) far into the future. In other words, "*tell us your story"*.

Describe who was involved in the development of this proposal and what level of support you have from community members, health care providers, and facility owners. Explain how soon the project will be construction-ready (including having secured funding for community cost-share); what project tasks are complete and what remains to be done.

Executive Summary:

3. BACKGROUND INFORMATION

A. Applicant Description

1. Provide a brief description of the Applicant's organization.

2. Describe the relationship between the Applicant and the Organization that provides funds for the delivery of health care services (salaries, supplies, equipment).

3. Describe the relationship between the Applicant and the Organization that provides funds for facility (building-related) expenses and maintenance.

4. If your building will be multi-use, describe how the Organization(s) that will occupy the non-clinic portion of the building will share facility expenses.

Note: Multi-use is defined as a building that will house both clinic (medical, dental, mental health, itinerant quarters) and non-clinic programs (e.g., Tribal/City offices, Head Start, Washeteria, etc)

B. Current Conditions

1. Current Facility Condition

If a Code and Conditions survey has been completed for your facility, copy the "Executive Summary" and the "Conclusions and Recommendations" sections and label as ATTACHMENT #3.1

If a Code and Conditions survey was NOT done for your facility, describe your current facility—its condition, adequacy, suitability for continued use, and other pertinent information. Include third-party documentation if available.

Describe your current Operations & Maintenance (O&M) Plan. This includes plans to pay for utilities, janitorial services, and other expenses; to keep the facility in good condition; to reserve funds for repairs, etc. List the sources of funds that support the O&M of the facility.

2. Maintenance Deficiencies

Does your current facility have a backlog of repairs/maintenance due to lack of funding for this activity? ___ Yes ___ No

If YES, please discuss your plans for maintaining the new facility.

4. MARKET ANALYSIS

A. Population to be served

1. Local Competition

Is your clinic the only medical provider in your community / service area?

___ Yes ___ No

If NO, identify the other providers of care and describe the level of services they offer.

2. Market Share

Do you expect 100% of the population in your service area to use your clinic?

___ Yes ___ No

If NO, briefly *(less than one page)* describe what portion of the population needs the services of your clinic and why. Include year-round and seasonal patients.

3. Potential for Increased Use of Clinic Services

- Are there factors that will increase the demand for your services? (e.g. new development in the area – construction, tourism, etc.)
- Do you have plans to provide additional services which will increase the number of patients using your clinic?

Please explain:

B. Healthcare Coverage (Insurance or Other) of Population

Complete the table based upon the healthcare coverage (insurance or other sources) of patients served: This information can be obtained from clinic records, Medicaid and Denali KidCare data can be obtained from the state Medicaid program. If this information is not readily available, estimate the number and explain how you came up with the estimate.

Enrolled (Covered):	Number of Patients	Source of Data
Indian Health Service, P.L. 93-638, similar funding mechanisms		
Denali KidCare		
Medicaid		
Medicare		
Commercial / third-party insurance (private or public)		
Uninsured: Those without eligibility/ability to access any type of insurance or medical assistance		
TOTAL		

Patient numbers may be duplicated since patients may have multiple sources of coverage
IHS beneficiaries, commercial insurance, Medicaid or Medicare

5. SERVICES AND FACILITY

A. Services to be Offered

1. Briefly** (less than one page) **state the identified healthcare access problem(s) to be addressed and the goals to be achieved. (This may be restated from the Problem Statement in Section III of the RFP) Has this changed since you completed the RFP?

2. Identification of Services

Complete *Form A – Schedule of Services Offered*

Describe any significant changes in services between the old and new clinics

3. How will the new clinic improve the QUALITY of care provided to patients?

4. Patient Visit Data

In order to complete the budget section of your Business Plan, you need to determine the activity level of services you will be providing. The activity level will be used as a basis for estimating revenue and expenses.

How many patient visits occurred in the past year? _____

from locally based providers _____ # from itinerant providers _____

Please indicate your definition of "visits" and your source of information

What is the annual unduplicated patient count for the past year? _____
(Total # of individual patients seen, regardless of how many times they came in during the year)

5. Patient Visit Forms

Complete *Form C – Schedule of Patient Visits*.

If your patient volume has a seasonal change of 25% or more, you must also complete *Form C (1) – Supplemental Schedule of Patient Visits by Month*

B. Facility Size, Type and Location

The Denali Commission recommends the following clinic square footage based upon community size:

Population:	*<100*	*100-500*	*500-750*	*750+ or serving multiple communities*
Health Clinic Size:	*1,500 Sq Feet*	*2,000 Sq Feet*	*2,500 Sq Feet*	*user defined*

NOTE: Please check the Denali Commission website (www.denali.gov) for future policies regarding funding beyond minimum space guidelines for Small clinics and funding limitation on maximum space for Large clinics.

1. How many square feet are you planning? _____

If your design is already underway, include a basic floor plan and a furniture plan as ATTACHMENT 5.1, if available.

2. If your community has a population of 750 or less, do you intend to use the Denali Commission prototype design? ___N/A ___ Unknown ___ Yes ___ No

If you believe it is necessary to differ from the prototype design and/or square footage recommendations, please state your reasons.

3. Will the facility house multi-use programs? ___ Yes ___ No

Note: A facility may house both essential primary care services (medical, dental, mental health, itinerant quarters) and multi-use programs (e.g., Tribal/City offices, Head Start, Washeteria, etc)

If YES, identify the other tenants, organizations and programs that will share your facility and why you chose to combine the programs in one building:

What is the size of the multi-use space in square feet? _____Square feet

4. Appropriateness of Size, Design, & Cost

Discuss the appropriateness of size, design, and cost of your proposed project for the service area. Include information that shows that the proposed building is the most appropriate and cost-effective approach to address the identified need(s).

5. Location

Describe the general location (not the legal description) of your new facility and the major factors involved in choosing it.

If your site has been selected or narrowed down to a few alternatives, include a site plan as ATTACHMENT #5.2

C. Hours of Operation

List the days of the week, times of day and/or months of the year that the facility will be open.

6. PERSONNEL

A. Providers and Staff

1. What organization is responsible for staffing the clinic? (Applicant, Community, Regional Health Corporation, etc.)

2. Staffing / Salaries & Wages Worksheets

Complete the table showing both permanent and itinerant personnel: Include only those hours DIRECTLY involved in operation of the clinic. Insert additional rows if necessary.

Position Titles	Current Staff			Staff Required for New Clinic		
	On-Site or Itinerant?	# people	FTE's Full-Time Equivalents	On-Site or Itinerant?	# people	FTE's Full-Time Equivalents

TOTALS						

Form F – Salaries & Wages Worksheet **is optional**. This form is used to help you calculate salary expense for the budget. Include administrative personnel if they work in the clinic itself. If the amounts are known, input the salary expense directly into *Form E- Expense Budget*.

3. Clinical Supervision of Providers

Who supervises and provides medical direction to clinic providers? How is this accomplished (i.e., chart review, competency assessment, on-site visits)?

4. Staffing issues

Identify any staffing issues (e.g. difficulty in recruiting and retaining personnel) and steps taken to resolve these problems.

5. Organizational Chart

Provide an organizational chart showing current clinical and administrative staff and lines of supervision. If two or more organizations are involved in the clinic, provide one from each organization. If an organizational chart has been developed for the new clinic, provide it as well. Label as ATTACHMENT #6.1

7. MANAGEMENT

A. Organization Structure

Describe the relationships among the business partners responsible for the clinic including: the clinic owner, any local oversight or advisory body, the administrative staff and any other organizations involved in running the clinic. Discuss any anticipated changes to those relationships with the new clinic.

Name of Business Partner	Relationship with Clinic

B. Clinic Administration

Does the Applicant have experience in providing health care services? ___ Yes ___ No

What organization(s) administers the funding for health care services offered in the existing clinic? Include the name of the organization and contact information. Discuss changes that will occur with the new clinic.

C. Facility Administration/Management

Does the Applicant have experience in facilities maintenance / facilities management?

___ Yes ___ No

What organization(s) administers the funding for the operation and maintenance of the existing facility? Include the name of the organization and contact information. Discuss changes that will occur with the new clinic.

Describe the management of the facility (building), including the duties of any administrative employees who do not work in the clinic itself, but are primarily responsible for the operation and maintenance of the facility.

1. Third Party Facility Operator

Will an organization, other than the Applicant, operate and maintain the facility?
If YES, what is the name of the organization? ___ Yes ___ No

Will the third party be responsible for providing adequate fire and liability insurance to cover the risk of loss of the facility structure and other leased fixtures? ___N/A ___ Yes ___ No

D. Independent Accreditation and/or Certification

Is your clinic accredited or certified? ___ Yes ___ No

What is name of the accrediting/certifying organization?

___ JCAHO Joint Commission on Accreditation of Healthcare Organizations www.jcaho.org
___AAAHC Accreditation Association for Ambulatory Health Care www.aaahc.org
___Other: Please identify:_____

Provide a copy of the letter or certificate issued by this organization. Label as ATTACHMENT 7.1

1. Quality Improvement Plans

If your clinic is not accredited/certified, what are your plans for improving the quality of health care services through performance improvement or quality assurance activities?

8. ESTIMATED PROJECT COST / COST SHARE

A. Estimated Project Cost

Part of the facility planning involves developing a cost estimate for your project. Choose one of these options for estimating your cost. Label documentation as ATTACHMENT 8.1

1. If you have a Code and Conditions Survey, you may attach a copy of the "New Clinic Analysis" section which shows the estimated cost.

-or -

2. You should work with your Regional Health Corporation Engineer, ANTHC Engineer or a private Architectural & Engineering firm to develop this estimate. Attach a copy of their cost estimate.

Estimated Total Cost of your Project: $_____

Source of estimate:

B. Applicant Cost Share – Calculation and Sources

Each Applicant is required to fund a minimum % based upon the "distressed" status of the community.

1. Cost Share Calculation

Line #	Description	Source	Clinic Space	Multi-Use Space
1	**Estimated Project Cost**	Question "A" above	$	$
2	**Community Status *** Circle the correct classification**	Distressed Community Criteria and Surrogate Standard***	Distressed Non-Distressed	
3	**Maximum Percentage of Denali Commission Funding**	Distressed = 80% Non-Distressed = 50%	%	0 %
4	**MAXIMUM AMOUNT OF FUNDING FROM THE DENALI COMMISSION FOR THIS PROJECT**	Multiply Line (1) x Line (3)	$	$ **-0-**
5	**MINIMUM AMOUNT DUE FROM THE APPLICANT**	Line (1) minus Line (4)	$	
6	**Cash to be provided by the Applicant (in the bank, loan approval, grant approval, etc)**	Section 8 – B - **2**	$	
7	**Value of Donated Land**	Section 8 – B - **3**	$	
8	**Value of Land Improvements**	Section 8 – B - **4**	$	
9	**TOTAL KNOWN FUNDING FROM THE APPLICANT**	Add Lines (6) + (7) + (8)	$	

10	**Balance** - If the amount is greater than zero, project has identified adequate funding; **- If the amount is less than zero, project requires additional funding in this amount**	Line (9) minus Line (5)	$	

*** Go to www.denali.gov , click on the "Health Facilities" tab, click on the "Related Documents" tab, and then go to "Distressed Community Criteria and Surrogate Standard" for a listing of status by community.

Note that the only Applicant cost matches in this calculation are cash, donated land and land improvements.

NOTE: You must provide documents showing that you meet minimum cost share funding requirements before you can receive construction funding.

2. Cash Funding Summary

Identify the cost share amounts to be provided by you and by funding partners. Insert rows in the table if necessary.

Source:	Description	Amount	Status*
		$	
		$	
		$	
	TOTAL	$	

***Indicate "Status" by selecting one of the following options:**

(1) Funds have been secured and are in your bank account.

(2) Funds have not been received, but a funding agreement has been signed and executed.

(3) You have received written notification that funds have been approved.

(4) You have applied for funds and are waiting for funding approval.

(5) You are in the process of applying for funds

(6) You have not yet applied for additional funding.

Provide copies of supporting documentation (i.e. copies of agreements, written notification, etc.). Label as ATTACHMENT 8.2

3. Donated Land Value

The value of donated land can only be used as a cost share if the land is owned by the applicant. The donation of a lease is treated as an in-kind donation and does not qualify for cost share status.

Have you included land as part of your cost share? ___ Yes ___ No

	Estimated Value of Land	$

What method did you use to estimate a value for the donated land? (e.g. a BIA valuation; a commercial real estate dealer's appraisal or opinion letter; or recent valuation accepted for a similar lot in the community).

Provide supporting documentation regarding the valuation. Label as ATTACHMENT 8.3

4. Value of Land Improvements

In some cases the costs of improvements to the clinic site can be used as cost share. Examples include extension of utilities, site clearing, imported/placed sand and gravel, and parking lots.

Have you included improvements as part of your cost share? ___ Yes ___ No

	Estimated Value of Land Improvements	$

Provide documentation to demonstrate the value of these improvements. Label as ATTACHMENT 8.4

9. FINANCIAL DATA

A. Overview

This section presents an overall financial budget for the clinic operations by combining the total revenue, health care services expenses, and facilities (Operations & Maintenance) expenses. It is intended to indicate the overall sustainability of the proposed new clinic, including both provision of services and maintenance of the facilities.

If two organizations are involved in funding the clinic (e.g. a village pays for the facility utilities, maintenance, etc. and the Regional Health Corporation pays for the provider and supplies), you must include revenue and expenses specific to the new clinic from both organizations.

B. Financial Data

1. Current Year Financial Reports – Health Care Services

Provide a copy of the most recent audited financial statements for the organization that will be funding the delivery of health care services. Include the auditor's Opinion Letter, Balance Sheet, Income Statement and Statement of Cash Flows. Label as ATTACHMENT 9.1.

If the clinic is part of a larger organization, provide a copy of the current year budget for the organization. Label as ATTACHMENT 9.2

2. Current Year Financial Reports - Facility Operations & Maintenance

Provide a copy of the most recent audited financial statements for the organization that will be funding the facility-related revenues and expenses. Include the auditor's Opinion Letter, Balance Sheet, Income Statement and Statement of Cash Flows. Label as ATTACHMENT 9.3.

If the clinic is part of a larger organization, provide a copy of the current year facility budget for the organization. Label as ATTACHMENT 9.4

3. Expense Budgets

There are 3 columns on the budget forms. The first column is for financial information about the existing clinic. The columns for "Year 1"and "Year 2" are for budgets for the new clinic. Note that these forms are also available in Microsoft Excel format.

- **Health Care Services Expense** (Does not include expenses related to the facility itself)
  Complete *Forms C through F*. Transfer the totals to *Form B – Budget Summary.*
- **Facility Operations & Maintenance Expense** (Does not include expenses related to the provision of care)
  Complete *Forms F and G*. Transfer the totals to *Form B – Budget Summary*.

4. Financial Support Resolution

If the budget includes revenues in Form B (Line 5m) that are not directly generated by or specifically received by the clinic, a resolution of financial support will be required. This includes organizations that receive grant funding or contract healthcare funding, and allocate funds to individual programs and/or satellite clinics.

A sample resolution is included at the end of this document.

If you need to complete a resolution, complete the following:

Line 5m – Year 2 $_____

x 30 years x 30

= $_____ (total estimated amount of financial support)

5. Financial Sustainability

Does your facility budget clearly provide for all expenses required to sustain operations over the life of the facility, including all necessary preventive maintenance activities and appropriate reserves for major repairs? ___ Yes ___ No

If NO, please explain.

Does *Form B - Budget Summary* show enough revenue to cover all expenses? (In other words, Does your plan demonstrate overall financial sustainability)? ___ Yes ___ No

If NO, how do you plan to cover/fund this shortfall?

C. Financial Opportunities

1. Patient Billing

Do you currently bill insurance for services offered to patients? ___ Yes ___ No

If NO, please explain why not:

2. Revenue Improvement

How do you plan to increase patient revenue and/or non-patient revenue in the future, (i.e. increase services offered, include more people in your patient base, bill Medicare, Medicaid or other insurance, pursue other grant funding, etc)?

3. Future Program Funding

If you anticipate obtaining funding that is not included in your budget, please list the anticipated source of these funds below:

Program Funds	Expected Source of Funds
Federal Grants	
State Grants	
Other Grants	
Community Support	
Other Funding (specify)	
Insurance Billing (Medicare, Medicaid, Blue Cross, etc.)	

4. Cost Control

What are your plans for controlling costs for the new/renovated clinic?

10. CHECKLIST OF APPLICATION MATERIALS

_____ Completed Business Plan document

_____ ATTACHMENT 3.1 Code and Conditions "Executive Summary" & "Conclusions and Recommendations" sections

_____ ATTACHMENT 5.1 Basic Floor Plan and Furniture Plan

_____ ATTACHMENT 5.2 Site Plan

_____ ATTACHMENT 6.1 Organization Chart

_____ ATTACHMENT 7.1 Accreditation/Certification Letter or Certificate

_____ ATTACHMENT 8.1 Project Cost Estimate

_____ ATTACHMENT 8.2 Documents verifying cost share

_____ ATTACHMENT 8.3 Documents verifying land value

_____ ATTACHMENT 8.4 Documents verifying land improvements value

_____ ATTACHMENT 9.1 Audited Financial Statements – Organization

_____ ATTACHMENT 9.2 Current Budget - Organization

_____ ATTACHMENT 9.3 Audited Financial Statements – Organization

_____ ATTACHMENT 9.4 Current Budget - Organization

_____ Forms "A" through "G"

_____ Resolution of Financial Support

11. DEFINITIONS

ANTHC
Alaska Native Tribal Health Consortium

Code and Conditions Survey
A survey of local health facilities by an ANTHC contracted engineer that determines the deficiencies in the facility and the approximate cost to repair the deficiencies or replace the clinic.

Contractual Adjustments
The difference between patient charges (Gross Revenue) and pre-determined payments (for example Medicare fee schedule amounts). Can be calculated as a percent of Gross Revenue

Cost Share
The applicant's share of the project cost, which consists of cash contributions and/or donation of land and land improvements.

Deductions from Revenue
The difference between the amount charged and the amount you expect to be paid. Includes contractual adjustments, sliding fee scale discounts, write-offs, and bad debt.

FTE – Full Time Equivalent
Hours paid in one year to measure staffing. 1 FTE = 2,080 hours (52 weeks x 40 hours per week).

Gross Patient Revenue
The total amount charged to patients for services rendered.

Multi-Use Facility
A building that will house both clinic (medical, dental, mental health, itinerant quarters) and non-clinic programs (e.g., Tribal/City offices, Head Start, Washeteria, etc)

Net Patient Revenue
The total amount collected (cash received) for services rendered to patients.

Non-Patient Revenue
Revenue from sources other than patient visits. Includes grants and other subsidies.

Open Door Policy/Open Access
The Denali Commission requires that all health care facilities that it funds be open to all who seek service and can pay for this service. At a minimum, this policy requires that anyone who can pay directly for the health services must be allowed to obtain medical attention in the facility.

Operations and Maintenance Plan
A plan which shows that you are able to pay for heat, electricity, custodial work, regular repairs and maintenance, and have a fund to pay for more extensive repairs that will be required as the facility ages.

Planning/Design
Developing architectural and engineering plans; obtaining permits and environmental and archaeological clearances; and completing whatever other steps are necessary to bring the project to the Construction Ready stage.

Site Control
Proof of legal control of the site either through ownership or 30-year lease.

Sustainability
Making sure that the owner of the facility and the provider of health care services have sufficient funds to keep the clinic open far into the future. Refer to the "Resolution regarding sustainability for Denali Commission funded infrastructure projects" on the Denali Commission website at http://www.denali.gov/content/Activities%20PP&F/Resolutions/Resolution01-15.pdf

Third-Party Billing
Billing someone other that the patient for services offered. This is usually an insurance company.

Unbilled Visits
In an effort to capture all activity, please include any visits that you track but do not bill for individually. (e.g. IHS beneficiaries that are not billed per visit)

Unduplicated Patient Count
A count of the number of individuals who have visited the clinic over the reporting period, regardless of how many times they come in.

12. RESOURCES

Healthcare Needs Assessment:
Needs assessments can be formal or informal. The objective of an assessment is to determine the areas of greatest need in the community.
Informal:

- Telephone surveys, Written surveys and/or Input at community meetings

Formal: - Many organizations conduct needs assessments. Contact these organizations to find out if a needs assessment has been completed for your area or if you need assistance in coordinating an assessment.

- State of Alaska
  Joyce Hughes
  Community Health and EMS
  Alaska Division of Public Health
  3601 C Street, Suite 990
  Anchorage, AK 99503
  907-269-2084 907-269-5236 (fax)
  joyce_hughes@health.state.ak.us

  Alaska Center for Rural Health
  Beth Landon
  Alaska Center for Rural Health
  3211 Providence Drive
  Diplomacy Bldg, Suite 530
  Anchorage, AK 99508
  907-786-6589
  anbml@uaa.alaska.edu

- Alaska Primary Care Association
  Carolyn Gove
  Community Development Specialist
  903 W. Northern Lights Blvd, Suite 105
  Anchorage, AK 99503
  907-929-2730 907-929-2734 (fax)
  carolyn@alaskapca.org

- Regional Health Corporations
- United Way

- Head Start
- Other grant programs

Technical Assistance Subcommittee:

Contact	Phone #	E-mail Address	Organization

Suzanne Niemi	929-2732	suzannen@alaskapca.org	Alaska Primary Care Association
Carolyn Gove	929-2730	carolyn@alaskapca.org	Alaska Primary Care Association
Marilyn Kasmar	929-2722	marilyn@alaskapca.org	Alaska Primary Care Association
Pat Carr	465-8618	pat_carr@health.state.ak.us	State of Alaska, Div of Public Health
Joyce Hughes	269-2084	joyce_hughes@health.state.ak.us	State of Alaska, Div of Public Health
Noel Rea	269-5024	noel_rea@health.state.ak.us	State of Alaska, Div of Public Health
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Beth Landon	786-6589	anbml@uaa.alaska.edu	Alaska Center for Rural Health
Mary Anaruk	786-6589	Shamaran1@aol.com	Alaska Center for Rural Health
Joel Neimeyer	271-1459	jneimeyer@denali.gov	Denali Commission

Code and Conditions Survey:

- Code and Conditions Surveys were completed as part of a project of the Denali Commission and the Alaska Native Tribal Health Consortium (ANTHC)
- If you have questions about your report, please contact ANTHC:
  Chet Kraft 907-729-4080
  Dan Wright 907-729-3509

Financial Data

- All organizations involved in the operations of the clinic and the facility must have input into the preparation of the financial data section. Each group must submit information so that an analysis of the financial viability is possible.

13. FORMS

A. Form A - Schedule of Services Offered

Page 1 of 2

Services *(Numbers below correspond to questions in the "Facilities Needs Assessment Questionnaire")*	Currently Offered (yes/no)	To be offered in new clinic (yes/no)	Notes
Basic primary care related to*:*			
P1.1 Family health			
P1.2 Emergency medical treatment			
P1.3 Substance abuse diagnosis			
P1.4 Substance abuse treatment			
P1.5 Mental health diagnosis			
P1.6 Mental health treatment			

Preventive health services			
P1.7 Prenatal and perinatal services			
P1.8 Breast and cervical cancer screening			
P1.9 Well-child services			
P1.10 Immunizations			
P1.11 Supplemental nutrition program (WIC)			
P1.12 Family planning services			
P1.13 Preventive dental services			
P1.14 Dental treatment services			
P1.15 Patient education			
P1.16 Other preventive health services (identify and discuss the Business Plan under Services Offered)			

Laboratory, radiological, and pharmacy services			
P1.17 CLIA waived tests			
P1.18 Specimen collection for shipment to referral lab			
P1.19 Provider-performed microscopy			
P1.20 Moderate complexity lab			
P1.21 Ultrasound			
P1.22 X-ray			
P1.23 Mammography			
P1.24 Pharmacy services			

Form A - Schedule of Services Offered

Page 2 of 2

Services *(Numbers below correspond to questions in the "Facilities Needs Assessment Questionnaire")*	Currently Offered (yes/no)	To be offered in new clinic (yes/no)	Notes
Patient care management services			
P1.25 Referral of patients to providers			
P1.26 Counseling and follow-up services to assist patients to become eligible for health care coverage			
Services that help individuals to use the clinic			
P1.27 Outreach			
P1.28 Home to clinic transportation			
P1.29 Language interpretation			
P1.30 Sliding fee scale / reduced rates			
P1.31 Alternate / extended hours			
Emergency medical services			
P1.37 First responder services			
P1.38 Ambulance services			
P1.39 Ability to provide advanced cardiac life support in clinic			
P1.40 Dedicated area for dealing with emergency patients			
P1.41 Radio/phone communications between clinic & emergency medical personnel			
Other services			
Telehealth services			
On-site administrative services			

B. Form B - Budget Summary– Health Care Services & Facility Operations

		Source	Existing Clinic	Year 1	Year 2
1	**PATIENT VISITS**	Form C			
	PATIENT REVENUE				
2a	Medical	Form D			
2b	Dental	Form D			
2c	Mental Health	Form D			
2d	Other	Form D			
2e	Misc	Form D			
2	**Total Gross Patient Revenue**	Add Lines 2a-2e			
	DEDUCTIONS FROM REVENUE				
3a	Contractual Adjustments	___%			
3b	Write-Offs / Bad Debt Expense	___%			
3c	Sliding Fee Scale/Discounts	___%			
3	**Total Deductions from Revenue**	Add Lines 3a-3c			
4	**NET Patient Revenue**	Line 2 - Line 3			
	NON-PATIENT REVENUE				
5a	Local Support				
5b	State Grants				
5c	Community Health Center Grants				
5d	Other Federal Grants				
5e	Private Foundation Grants				
5f	IHS Compacts/Contracts/Tribal Shares received directly by clinic				
5g	Contributions/Donations				
5h	Fund Raising				
5i	Interest Income				
5j	Other				
5k	IHS Village Based Clinic Lease Program				
5l	IHS Maintenance & Improvement Program				
5m	Allocation from Regional Health Corp or Other organization				
5	**Total Non-Patient Revenue**	Add Lines 5a -5m			
6	**TOTAL REVENUE**	Line 4 + Line 5			
	EXPENSES				
7	Salaries & Wages	Form E			
8	Employee Benefits	Form E			
9	Travel	Form E			
10	Minor Equipment (items <$5,000)	Form E			
11	Supplies	Form E			
12	Contractual Services	Form E			
13	Other	Form E			
14	Facility Expenses	Form G			
15	**TOTAL EXPENSES**	Add Lines 7 to 14			
REVENUE OVER/(UNDER) EXPENSES		Line 6 - Line 15			

C. Form C - Schedule of Patient Visits

	Source	Existing Clinic	Year 1	Year 2
Provider Type				
Community Health Aide / Practitioner				
Nurse				
Emergency Medical Technician				
Physician Assistant / Nurse Practitioner				
Physician				
Subtotal Medical Visits – To Form D				
Dentist				
Dental Hygienist / Tech				
Dental Health Aide				
Subtotal Dental Visits – To Form D				
Mental Health Provider / Social Worker				
Subtotal Mental Health Visits – To Form D				
Community Health Representative				
Health Educator				
Subtotal Other Visits – To Form D				
TOTAL VISITS – To Form B				

Form C (1) – Supplemental Schedule - Patient Visits per Month

****This form must be filled out if your patient volume has a seasonal change of 25% or more****

Show the number of patient visits monthly/annually by provider type

A separate form is needed for each year Year (circle one): Existing Year 1 Year 2

Provider Type	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Total**
Community Health Aide / Practitioner													
Nurse													
Emergency Medical Technician													
Physician Assistant / Nurse Practitioner													
Physician													
Total Medical Visits To Form D													
Dentist													
Dental Hygienist / Tech													
Dental Health Aide													
Total Dental Visits – To Form D													
Mental Health Provider / Social Worker													
Total Mental Health Visits – To Form D													
Community Health Representative													
Health Educator													
Total Other Visits – To Form D													
TOTAL VISITS – To Form B													

D. Form D - Revenue Worksheet – Health Care Services

	Source	Existing Clinic	New Clinic Year 1	New Clinic Year 2
2a **MEDICAL REVENUE**				
Medical Visits	From Form A			
Average Charge per Visit				
Total Medical Revenue	visits x charge			
2b **DENTAL REVENUE**				
Dental Visits	From Form A			
Average Charge per Visit				
Total Dental Revenue	visits x charge			
2c **MENTAL HEALTH REVENUE**				
Mental Health Visits	From Form A			
Average Charge per Visit				
Total Mental Health Revenue	visits x charge			
2d **OTHER REVENUE**				
Other Visits	From Form A			
Average Charge per Visit				
Total Other Revenue	visits x charge			
2e **Miscellaneous REVENUE**				
Total Misc Revenue				

E. Form E - Expense Budget –Health Care Services

Totals by category must be entered in *Form B - Budget Summary*

Page 1 of 2

	Source	Existing Clinic	New/Expanded Clinic Year 1	New/Expanded Clinic Year 2
7 SALARIES & WAGES (use *Form F - Salaries & Wages worksheet* to calculate salaries)				
7a Medical Providers	Form F			
7b Dental Providers	Form F			
7c Mental Health Providers	Form F			
7d Administrative Staff	Form F			
7e Clinical Staff	Form F			
7f Other	Form F			
Total Salaries & Wages	Add Lines 7a - 7f			
8 EMPLOYEE BENEFITS ** (calculate as a percentage of total Salaries & Wages)				
8a Percentage				
Total Employee Benefits	Total Salaries x Line 8a			
9 TRAVEL *(airfare and per diem)*				
9a Provider Travel				
9b Administrative Staff				
9c Clinical Staff				
Total Travel	Add Lines 9a – 9c			
10 MINOR EQUIPMENT *(Items less than $5,000 – DO NOT include capital items)*				
10a Medical				
10b Dental				
10c Information Systems				
10d Office/Administrative				
10e Other				
Total Minor Equipment	Add Lines 10a-10e			
11 SUPPLIES – *(items consider "disposable" or that are consumed in use)*				
11a Medical				
11b Dental				
11c Lab				
11d Pharmacy				
11e X-Ray				
11f Office/Administrative				
11g Other				
Total Supplies	Add Lines 11a -11g			

Form E - Expense Budget –Health Care Services
Page 2 of 2

	Source	Existing Clinic	New/Expanded Clinic Year 1	New/Expanded Clinic Year 2
12 CONTRACTED SERVICES				
12a Provider Services (Locums Tenems)				
12b Lab Fees				
12c Dental Lab Fees				
12d Radiology				
12e Transcription				
12f Other (Hazardous waste, etc)				
Total Contractual Services	Add Lines 12a –12f			
13 OTHER				
13a Consultant Fees				
13b Continuing Education				
13c Equipment Maintenance				
13d Equipment Rental/Lease				
13e Information Services/ Computer Fees				
13f Interest Expense				
13g Legal/Accounting/Audit Fees				
13h Liability Insurance				
13i Non-Staff (Board) travel				
13j Postage / Shipping				
13k Recruitment / Moving Exp				
13l Subscriptions / Journals / Dues				
13m Telephone / Internet / Cable				
13n Other				
Total Other	Add Lines 13a – 13n			
TOTAL HEALTH CARE SERVICE EXPENSES				

F. Form F - Salaries and Wages Worksheet (optional)

Page 1 of 2

A separate form is needed for each year Year (circle one): Existing Year 1 Year 2

NOTE: If personnel work for more than one clinic, or also spend time on another program, only include those hours that are directly related to this clinic

*****HEALTH CARE SERVICES*****

Position	Hours per Week	x Weeks per Year	= Annual Hours	x Hourly Rate	= Annual Wages
Comm Health Aide/Practitioner				$	$
EMT				$	$
Nurse Practitioner/ Physician Assistant				$	$
Physician				$	$
Other				$	$
SUBTOTAL MEDICAL	To Form E, Line 7A				$
Dentist				$	$
Dental Hygienist				$	$
Dental Technician				$	$
Dental Health Aide				$	$
Other				$	$
SUBTOTAL DENTAL	To Form E, Line 7B				$
Mental Health Provider				$	$
Mental Health Aide				$	$
Social Worker / Other				$	$
SUBTOTAL MENTAL HEALTH	To Form E, Line 7C				$
Receptionist				$	$
Insurance Biller				$	$
Accounting/Payroll				$	$
Administrative Assistants				$	$
Manager(s)				$	$
Director / Administrator				$	$
Other				$	$
SUBTOTAL ADMIN	To Form E, Line 7D				$
Medical Assistant/CNA				$	$
Nurse (RN/LPN)				$	$
Phlebotomist				$	$
Other				$	$
SUBTOTAL CLINICAL	To Form E, Line 7E				$
Community Health Rep				$	$
Health Educator				$	$
Other				$	$
SUBTOTAL OTHER	To Form E, Line 7F				$

Form F - Salaries and Wages Worksheet (optional)

Page 2 of 2

A separate form is needed for each year Year (circle one): Existing Year 1 Year 2

NOTE: If personnel work for more than one clinic, or also spend time on another program, only include those hours that are directly related to this clinic

*****FACILITY SERVICES*****

Position	Hours per Week	x Weeks per Year	= Annual Hours	x Hourly Rate	= Annual Wages
Custodian				$	$
Maintenance				$	$
Administrative				$	$
Other				$	$
SUBTOTAL FACILITY	To Form G, Line14A				$

G. Form G – Expense Budget - Facility Operations & Maintenance

14 FACILITY EXPENSES		Existing Clinic	Projected Year 1	Projected Year 2
14a Salaries & Wages - Building	Form F			
14b Benefits	% of Salary			
14c Building Rent				
14d Building Depreciation / Reserve for Repairs & Replacement				
14e Property Taxes				
14f Building Repairs				
14g Building Maintenance				
14h Building Insurance				
14i Building Supplies				
14j Utilities				
14k Janitorial				
14l Building Expense Other				
TOTAL FACILITIES EXPENSES	Add Lines 14A to 14L			

Building Square Feet			
Average Facility Expense per Square Foot (Total Facilities Expenses / Building Square Feet)	$	$	$

H. Resolution

Resolution of Financial Support

RESOLUTION NUMBER _____

A RESOLUTION of the **[1] _____ confirming an intent to provide funding for the _____ Clinic.

WHEREAS, the Council/Board of Directors of **[1] _____ (hereinafter the "Applicant") wishes to provide a Health Care Clinic in the community of _____ , and

WHEREAS, the Applicant wishes to participate in the Denali Commission Rural Primary Health Care Facilities Program, and

WHEREAS, the Denali Commission requires that construction projects are sustainable in the long term (defined as 30 years), and

WHEREAS, the Business Plan of the clinic includes revenues that are not directly generated by or specifically received by the clinic, and

WHEREAS, the Applicant receives grant funding or contract healthcare funding, and allocate funds to the _____ clinic.

NOW, THEREFORE, BE IT RESOLVED THAT the Applicant's intent is to allocate funding for the _____ clinic as generally outlined in the Business Plan to assure sustainability for the facility and for services provided for a period of at least 30 years.

PASSED AND APPROVED BY THE _____

on _____, 2002.

IN WITNESS THERETO:

By: _____ Attest: _____

Signature and Title

[1] Insert name of organization that is submitting the application